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f. Change of Class: An existing provider becoming a Class III facility will be paid a plant cost component determined using the principles stated in Sections IV.B.1. and IV.B.2. of this plan.

C. Variable Cost Component

For Class II provider cost reporting periods, beginning on or after January 1, 1989, the variable cost component of the prospective rate will be based on a submitted cost report. Cost will be settled retrospectively against a fixed ceiling using allowable cost principles, as defined in Section III of this plan. Fixed variable component ceilings will be determined for each facility based on the submitted budget.

For provider cost reporting periods beginning on or after April 1, 1986, the variable cost component for long term care facilities in Classes I and III will be determined in accordance with the following sections. Rate setting for prior periods will be made in accordance with the State Plan in effect at the beginning of the provider's rate setting period.

1. Variable costs are defined as total allowable costs allocated to base and support costs in the routine service centers. Allowable costs and expenses are determined allowable in accordance with Medicare Principles of Reimbursement as modified by Section III of this plan. The agency's cost reporting forms specifically allocate routine service center costs into base, support and plant costs. Costs of other services are also allocated on the cost reporting forms into ancillary service centers (retrospectively cost settled or paid fee-for-service), home for the aged service centers, and other nonreimbursable service centers.

2. The variable cost component consists of two subcomponents--the base cost component and the support cost component. Base costs are generally defined as those costs which cover activities associated with direct patient care. Special add-ons to provide cash flow for anticipated costs that are not included in the cost base period may also be included in the rate. Effective for cost reporting periods beginning on or after October 1, 1990, base costs include: 1) labor costs and related benefits and payroll taxes except medical records, medical director, general and administration, housekeeping, and operation of plant cost categories; 2) raw and processed food costs; 3) the cost of all utilities; 4) consultant costs for base cost categories from a related organization; 5) the cost of contracted agency nursing personnel; 6) linen; 7) all worker compensation costs; and 8) all other costs incurred in base cost categories except as specifically defined as support costs.

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Effective for cost reporting periods beginning on or after October 1, 1990, support costs are considered to be all other variable costs, including administrative costs; consultant costs regardless of the department with which the cost is associated; all equipment repair and maintenance costs; and all materials and supplies except for those included in base costs. More specifically:

a. Base costs are defined as allowable costs (i.e., with related organization profit removed) for:

1) Payroll related costs (salaries, wages, related payroll taxes and fringe benefits) for core departments of nursing, dietary, activities, social services and laundry plus these other major cost items: raw and processed food; linen (does not include mattresses or springs); workers' compensation; utility costs; consultant costs for base cost categories from related organizations; and supply costs incurred in all base cost departments.

2) With the exception of nursing services, purchased services and contract labor from unrelated parties or from related organizations, incurred in lieu of base costs as defined in Section 1, immediately above, are separated into base and support costs using the industry-wide average base-to-variable-cost ratio. The industry-wide average base-to-variable-cost ratio will be updated at least annually. The purchased services to be allocated using this method are exclusively limited to contracted services for costs incurred in base cost categories. All other purchased services are defined as support costs.

b. Support costs are defined as:

The payroll related costs of the departments of housekeeping and maintenance of plant operations; administrative costs; all consultant costs, all equipment maintenance and repair costs; and all other allowable variable costs, purchased services and contract labor not specified as base costs (i.e., variable costs minus base costs).

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c. The allowability of costs shall be determined in accordance with Medicare Principles of Reimbursement as modified in Section III above.

3. The rate determination methods using base and support costs to obtain the variable cost component are described below:

a. A provider's base cost component is determined as per patient day base costs taken from the provider's fiscal year two years prior to the prospective year times an inflationary adjustor to update costs from the base year to the prospective year. The base cost component will be rebased (recalculated) annually to reflect the more current costs of both the resource needs of patients and the business expenses associated with nursing care. The annual inflationary adjustor will be established by the state legislature for Class I and Class III facilities.

1) For the period October 1, 1999 through September 30, 2000, the historical inflationary adjustor will be zero percent (0%) for general inflation plus a wage pass-through program of up to $.50 per hour for all nursing facility employees with the exception of employees constrained by the Owner/Administrator Compensation limits described in Section III.

The prospective inflationary adjustor will be four percent (4%) general inflationary factor plus a wage pass-through program of up to $.75 per hour for all nursing facility employees with the exception of employees constrained by the Owner/Administrator Compensation limits described in Section III.

2) The inflationary adjustors used will reflect zero percent (0%) for the historical year and four percent (4%) for the forecast year.

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3. The State will conduct annual studies relating actual industry costs to the inflationary adjusters used in setting prospective rates, within the context of the total rate. MSA will share the study results at the next Long Term Care Liaison meeting following completion of the study.

   If more than 20 percent of facilities in a class identify and document that new State or Federal requirements are anticipated to add more than 1 percent to the classwide average rates of facilities, the State will convene a work group that includes provider representatives to discuss and recommend adjustments to the prospective reimbursement system top meet those new costs. The state agency will act upon these recommendations within 90 days of their receipt. This provision does not apply to minimum wage changes April 1, 1991.

b. A provider's support cost component is determined as the provider's base cost component times the provider's support-to-base (S/B) ratio. Where:

   1) For Class I and Class III Facilities Rate Periods Beginning On Or After October 1, 1994:

      a) The provider's S/B ratio is determined from the most recent, audited fiscal year.

      b) The provider's S/B ratio is limited to the 80th percentile S/B ratio for the provider's bed size group. The bed size groups shall be 0-50, 51-100, 101-150, and 151 plus nursing care beds in the facility or nursing complex.

      c) The provider's S/B ratio is rebased annually, from the most recent audited base period, regardless of ownership.

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d) The 80th percentile support-to-base ratio limits will be determined quarterly from the most recent audited, updated support costs by bed size grouping. The 80th percentile support-to-base ratio limit will be determined in a like manner as the variable cost limit described in Section IV.2.d.2) of this plan. Support costs from a providers most recent audited cost report will be included in the support-to-base ratio limit calculation no later than the quarter immediately following 170 days from the filing of an acceptable cost report with the state agency, if the report is not under expedited appeal.

2) Class I and Class III Facility Rate Periods Beginning On or After October 1, 1994

A provider's support cost component is determined as per patient day support costs taken from the provider's fiscal year two years prior to the prospective year times an inflationary adjustor to update costs from the base year to the prospective year. The applicable inflationary adjustor is identified in Section 3.a.

Support to base ratios will be calculated annually and used in calculation of support to base ratio limits as described in Section 1 above. An individual facility support limit will be computed by multiplying the applicable ratio limit for the quarter and for the provider's facility size grouping times the provider's per patient day base cost for the period. If a provider's support component exceeds the limit, the provider will be paid the limit amount, which is based on the appropriate bed size grouping.

C. A provider's variable rate base is determined as the sum of the base cost component and the support cost component.

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d. The provider's variable cost component is determined as the lesser of the variable rate base or the provider's classwide variable cost limit (VCL), where:

1) The classwide VCL is the 80th percentile of updated allowable per patient day variable costs for nursing care facilities in the class. The VCL is determined as the classwide 80th percentile updated to the prospective rate year using the appropriate inflationary adjustor for the class, less a reduction of one half of the appropriate prospective or historical period gross inflationary adjustor for the class to account for the wage pass through.

a) For Class III nursing facilities, the updated Medicaid per patient day variable cost is determined by multiplying the Medicaid per patient day variable cost for each provider cost by the appropriate DRI/McGraw-Hill Nursing Home Market Basket adjustor, less a reduction of one half of the appropriate prospective and/or historical inflationary adjustor to account for the wage pass-through, compounded annually to bring costs to a constant point in time. Medicaid per patient day variable cost for Class III facilities will be the provider's most recent, audited per patient day base cost times one plus the current rebased audited cost based support-to-base ratio.

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b) For Class I nursing facilities, the updated Medicaid per patient day variable cost is determined by multiplying the Medicaid per patient day variable cost for each provider cost by the appropriate DRI/McGraw-Hill Nursing Home Market Basket adjustor plus 1% per year, less a reduction of one half of the appropriate prospective and/or historical inflationary adjustor to account for the wage pass-through, compounded annually to bring costs to a constant point in time. Medicaid per patient day variable cost for Class I facilities will be the provider's most recent, audited per patient day base cost times one plus the current audited cost based support-to-base ratio. Base and support costs from a providers most recently audited report will be included in the VCL calculations no later than the quarter immediately following 170 days from the filing of an acceptable cost report with the state agency, if the report is not under expedited appeal.

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2) To determine the classwide VCL, the State first rank orders providers from the lowest to the highest updated Medicaid per patient day variable cost. The 80th percentile is then identified by accumulating Medicaid patient days of the rank ordered providers from the lowest updated per patient day variable cost provider until 80 percent of the total Medicaid days for these providers is reached. The updated Medicaid per patient day variable cost of the facility in which the last patient day was accumulated is the variable cost limit for the class of providers.

3) The variable cost limit for private institutions for the mentally ill and mentally retarded is computed by adding the dollar value of the nursing care time differential determined by the Department of Consumer & Industry Services and the dollar value of other additional required routine services to the VCL determined for the Class I facilities.

4. Class I Special Rate Relief

A. Eligibility for Class I Special Rate Relief:

A Class I provider may apply for rate relief from the normal rate setting process if the Medicaid rate is insufficient and the provider meets the eligibility criteria:

1. The facility's current variable cost component of the Medicaid rate is at or below the corresponding classwide average variable cost (the sum total of variable costs for all LTC facilities in a class divided by the sum total of patient days for facilities in the class).

2. The provider must be the current provider per the Medicaid provider agreement, except when applying under criteria 3.e.

3. The provider must meet one of these additional criteria:

a. The provider's audited Medicaid Variable Cost for both of the two years prior to the rate relief year must be in excess of the Medicaid Variable Rate Component plus incentives and associated rate add-ons.

b. The provider has a MDCIS citation to increase staffing or meet specific requirements.

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c. The provider's cost report is inadequate due to change in ownership or bankruptcy.

d. The facility's current Medicaid clients had a significant increase in needed resident care compared to the base year residents' care needs. The provider must use the Minimum Data Set for the comparison.

e. The facility is closing and provides more than 65% of Medicaid certified beds in that county. A prospective buyer may apply, and receive commitment, for special rate relief prior to finalizing the purchase of the facility.

B. Level of Special Rate Relief:

Providers with a variable rate component less than 80% of the classwide average variable cost qualify for Level I relief, which allows a provider to be reimbursed up to the classwide average cost and includes cost settlement limited to the classwide cost for the provider's respective rate period. Providers from 80% to 100% of the appropriate classwide average variable cost qualify for Level II relief, which allows for prospective rate determination by means of accelerated rebasing of the Provider's variable rate component. Accelerated rebasing is the use of the Provider's immediate cost reporting period during which the experienced difficulty occurred, to be used for the following rate year.

Rate relief will be subject to applicable allowable cost and reimbursement l limits, and is granted to a facility only once every seven years, regardless of ownership. The Medicaid program annually rebases a facility's reimbursement rate. If a facility does not spend the special rate relief, diverts the funds to other than patient care, or is repeatedly cited by the MI Department of Consumer & Industry Services survey for inappropriate care, then the rate will be lowered accordingly at the next rebasing process, if not sooner.

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6. Special Provisions: The variable cost component will be determined using special methods for providers that are "new providers" or have changed class. Special methods are required because there is no(or an inadequate) cost basis upon which to determine rates. Providers with newly purchased facilities or with major additions, renovations or new construction are not granted any special methods because there are historical variable costs upon which to base rates.

   a. New Providers: A "new provider," which is defined as a long term care provider in a facility that does not have a Medicaid historical cost basis and that has not provided care to Medicaid clients for a period of at least two years, will be paid in accordance with Section c. below.

   b. Change of Class: An existing long term care provider which becomes a Class I or III facility, will be paid in accordance with Section c. below.

   c. Payment Determination:

      1) During the first two cost reporting periods, providers defined in Sections a. and b. above will be paid a variable cost component equal to the class average of variable costs, updated by the appropriate inflationary adjustor for the class, less a reduction of one half the prospective and/or historical adjustor to account for wage pass-through, plus an incentive component determined as one-half the quality of care incentive subcomponent and a volume incentive subcomponent based upon the most recent available class average Medicaid/Medicare volume.

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      2) During subsequent periods, these providers' variable cost components will be determined by rebasing the base cost component in accordance with Section IV.C.3.a. above and applying the industry-wide average support-to-base ratio, or audited cost data, if available for setting the provider's support-to-base cost ratio and support cost component to which is added an incentive component determined in accordance with Section IV.D. below.

      3) In subsequent periods the provider's variable cost component will be determined using the methods in Section IV.C.1. through IV.C.3. above.

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D. Incentive Component

If a Class II provider cost settles below the ceiling rate, they will be paid a per patient day efficiency incentive of 50 percent of the difference between actual per diem cost and the ceiling, not to exceed $2.50 per patient day. Class II providers will not be paid any other incentive.

The provider's incentive component is the sum of the provider's volume incentive component and quality of care incentive component. Each incentive component is the incentive component basis times the respective incentive factor times the incentive portion. The volume incentive component is paid only within variable cost limits.

For rate setting periods beginning on or after November 1, 1987, the incentive component basis is 10.5 percent of the base cost component unless the facility is subject to the upper bound provision described below under item 2 . The incentives will be split between the two portions: Medicaid/Medicare volume and quality of care.

1. Incentive Component Basis

a) Effective October 1, 1990 for Class I facilities, the maximum Medicaid/Medicare volume incentive is 10 percent of the incentive component basis, and the maximum quality of care incentive is 30 percent of the incentive component basis.

b) Effective July 1, 1992 for Class III County Medical Care Facilites, the maximum Medicaid/Medicare volume incentive is 30 percent of the incentive component basis, and the maximum quality of care incentive is 30 percent of the incentive component basis.

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c) For Class III Hospital Attached Long Term Care Units the maximum Medicaid/Medicare volume incentive is 30 percent of the incentive component basis, and the maximum quality of care incentive is 40 percent of the incentive component basis.